

Money When You Need it Most

If you're like most American workers, your financial security, and your family's, depends on your paycheck. What would happen if you are hurt or lose your life in an accident and can't bring home that paycheck? The result could be financial tragedy. Accidents, unfortunately, happen every day – both on and off the job.



IN JUST ONE YEAR:

- ▲ Unintentional injuries continue to be the 5th leading cause of death.¹
- ▲ On the job, 3.5 million American workers suffered disabling injuries in 2007.¹
- ▲ In the home, there were 52,500 fatalities and 9.4 million disabling injuries in 2007.¹

Yet many American workers—perhaps you included—have no means of providing for themselves and their families if they are involved in an accident.

Paycheck Protection Plus® is a plan designed for workers like you. It is called Paycheck Protection Plus® because with it your income can continue after an accident even if your paycheck stops. Best of all, you won't have to pay any federal income taxes on benefits you receive from this policy.

Paycheck Protection Plus® combines many important accident benefits in one accident only policy, including protection on and off the job for total disability, hospitalization, medical treatment, death and dismemberment.

PREMIUMS					
Single Coverage Issue Ages ² :	1 Unit		Family Coverage Issue Ages ² :	1 Unit	
	Weekly	Monthly		Weekly	Monthly
18-40	\$3.50	\$15.17	18-40	\$5.50	\$23.83
41-50	\$4.00	\$17.33	41-50	\$6.00	\$26.00
51-60	\$5.00	\$21.67	51-60	\$7.00	\$30.33

- ▲ Pays benefits regardless of other insurance you may have. Cash benefits paid directly to you, or to your beneficiaries or to someone designated by you.
- ▲ Covers accidents on or off the job anywhere in the world, 24 hours a day, 365 days a year.
- ▲ Premium rates can only change for the entire policy class, not for individual policies.
- ▲ Premiums can be paid automatically through payroll deductions or by monthly bank draft.
- ▲ Plan can be continued if you leave your present job.
- ▲ The policy is guaranteed renewable until age 65.
- ▲ If within 30 days of receipt of the policy you are not 100% satisfied, just return the policy and your premium will be refunded.

PAYCHECK PROTECTION PLUS® AT-A-GLANCE Coverage and Benefit Amounts

Type of Accident Coverage	1 Unit
Total Disability Income Cash Benefit (8th day) Total disability occurs within 30 days after the accidental injury.	\$600/mo for 12 months \$300/mo for next 48 months for off-the-job Half as much for on-the-job No dependent coverage
Hospitalization Cash Benefit (1st day) Hospitalization must occur within 6 months of the accidental injury.	\$100/day for up to 90 days for off-the-job \$50/day for on-the-job \$50/day for dependent spouse and/or children*
Medical Treatment Cash Benefit Medical treatment must be received from a legally qualified physician within 60 days of the accidental injury.	Up to \$400 On and off job Insured, dependent spouse and/or children*
Accidental Death Cash Benefit	\$10,000 for insured \$4,000 for dependent spouse and/or children*
Dismemberment [†] : • Loss of both eyes, or both hands, or both feet or one hand and one foot from accidental injury	\$5,000 for insured \$2,000 for dependent spouse and/or children*
• Loss of one hand, or one foot or one eye from accidental injury	\$2,500 for insured \$1,000 for dependent spouse and/or children*
Common Carrier Accidental Death Benefit	\$20,000 for insured \$8,000 for dependent spouse and/or children*

*Available only if optional family coverage is elected. Dependent spouse must be under age 65 at the time the policy is issued. Dependent children (including future and legally adopted children) are unmarried children under the age of 21 (23 if a full-time student). Any dependent child who is mentally or physically handicapped and incapable of employment will not lose protection because of age.

[†]Loss of limb means actual severance. Loss of eyes means total and irrecoverable loss of sight. For multiple losses from one accident the benefit is limited to a single payment. Consult the policy for full benefits, exclusions and limitations. Amounts and benefits are subject to the terms of the policy when issued. Accident only coverage.

EXCLUSIONS

This Policy does not cover any death or injury, which results from:

1. Suicide or attempted suicide, or self-inflicted injuries intentionally inflicted while you are sane or insane.
2. Any poison or gas voluntarily taken, administered, absorbed or inhaled.
3. Intoxication or voluntary drug overdose, excluding those taken as medicine under a physician's prescription.
4. Disease or infirmity, unless resulting from an accident or occurring within 90 days of the accident.
5. Commission of, or attempt to commit, an assault, felony or a crime of violence or from fleeing, or resisting arrest.
6. Operating a vehicle on a racetrack or speedway in a race or speed test.
7. Insurrection, war or any act of war, declared or undeclared or participation in a riot.
8. Engaging in an illegal occupation.
9. Full-time active duty in the armed forces.
10. Operating, riding in or descending from any kind of aircraft, except as a passenger without aeronautic duties or any other specific duties in connection with aeronautic aircraft.
11. Claims for benefits due to a pre-existing condition will not be paid.

¹National Safety Council. Highlights from Injury Facts, 2009 Edition.

²Issue ages premium does not increase as you get older.

INDIVIDUAL ACCIDENT-ONLY POLICY

1. Proposed Insured: First Name _____ M. Initial _____ Last Name _____
 2. Residence: Street & No. _____ City _____ State _____ Zip _____
 Home Phone _____ Date of Birth _____ Age Nearest Birthday _____ Place of Birth _____ Sex _____ S.S.# _____
 3a. Name of Employer _____ b. Exact Job Duties _____ c. Employment Date _____
 4. Name of Beneficiary _____ Relationship to Proposed Insured _____

5. Complete this section if other eligible family members of the Proposed Insured are to be covered.

Name of Family Members to be covered	Sex	Relationship to Proposed Insured	Age	Date of Birth

6. Plan Requested

- Individual Coverage
 Family Coverage
 Number of Units
 1
 2
 3

7. Premium Payable

- Weekly
 Bi-Weekly
 Semi-Monthly
 Monthly
 Other _____
 Modal Premium \$ _____

8. Is there any existing monthly income/hospital income Insurance in force on the Proposed Insured or any eligible family member to be covered?
 Yes No If yes, give name(s) of the company issuing the insurance, type and amount of coverage _____
 9. Earned income is the total annual salary or wages, commissions, fees and other earned income, reduced by regular business expenses, but before all other deduction:
 10. Earned Income: At the current monthly rate of \$ _____ or current hourly rate of \$ _____
 11. Does your unearned income exceed \$5,000 per year? Yes No: If YES, give sources and amounts _____
 12. Have you been hospitalized for more than 5 days or been absent from work due to an accident or sickness for more than 5 consecutive work days during the past 12 months? Yes No If YES, please explain. _____
 13. Have you been treated for injuries suffered on or off the job within the past 12 months? Yes No Explain YES answers
 14. Are you currently under the care of a physician? Yes No
 15. Do you have any residual problems as a result of injuries that occurred during the past 12 months? Yes No
 16. Name and address of your personal physician and date last consulted _____

Insurance shall take effect on the application date. However, it is understood that the company shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid or that an authorization for payroll deductions has been signed by the applicant while the health and other conditions affecting the insurability of the Proposed Insured are as described in the application. No change in amount, classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the Proposed Insured. I hereby acknowledge receipt of the disclosure statement required by the Fair Credit Reporting Act.

I hereby authorize any physician, medical practitioner, hospital, clinic, Health Maintenance Organization, including Mayo, Kaiser Foundation, Veterans Administration, or other medical related facility, insurance company, the Medical Information Bureau, or any organization, institute, or person that has any record or knowledge of me or my family, or our health, medical history or physical condition, to give to Colorado Bankers Life Insurance Company or its reinsurer any such information including psychiatric histories and to testify as to such information.

This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility, (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

This authorization is valid for thirty (30) months after the date it is signed. A photostatic copy of this authorization shall be valid as the original.

Dated at _____ City _____ State _____ this _____ day of _____

Witnessed by _____ Licensed Resident Agent _____ Proposed Insured Signature _____

CBL A0 1/98 (MN) White & Yellow - Home Office Pink - Agent Gold - Applicant

DISCLOSURE STATEMENT

Information regarding your insurability will be treated as confidential. Colorado Bankers Life Insurance Co., or its reinsurer may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchanged on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you the Bureau will arrange a disclosure of any information it may have in your file. (Medical information will be disclosed to you.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 436-3660.

Colorado Bankers Life Insurance Co., or its reinsurer, may also release information in its file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

As a part of our normal procedure for processing your application for insurance an investigative consumer report may be obtained which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living, excluding sexual orientation. This information will be obtained through personal interviews with your friends, neighbors and associates.

Upon written request to the Underwriting Department, further information on the nature and scope of the report will be provided.

THIS PRE-WRITTEN NOTICE MUST BE DETACHED AND LEFT WITH THE PROPOSED INSURED.